considered are extremely large) and would be of no use in medical audit. Third, we prefer to use a system for evaluation of severity of disease that analyzes the modifications of basic pathophysiologic patterns of response to disease, as the APACHE II system does, because it represents in our opinion the best tool for risk evaluation in all kinds of patients.

The APACHE II system was applied in our work to high-risk patients only. We agree that APACHE II is not the best system to categorize the single patient admitted for scheduled surgery, but it may be a good research tool for high-risk surgical lung carcinoma patients, who represent a heterogeneous group. Finally, we think that the best results in terms of accuracy can be achieved in large series of patients.

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Salmonella Lung Abscess in a Patient with Acquired Immunodeficiency Syndrome

To the Editor:

Salmonella bacteremia is a well-recognized complication in immunocompromised hosts, including patients with acquired immunodeficiency syndrome (AIDS). The Salmonella organism is rarely isolated from the respiratory tract either premortem or at autopsy in patients with AIDS. We report a case of Salmonella lung abscess in an AIDS patient.

A 49-year-old Haitian man was admitted in December 1988 with a three-day history of weight loss, dyspnea, and cough. On examination, he was febrile and tachypneic and had rales in the left lung. His WBC was 1,400/mm³, with CD4 of 3/mm³. The human immunodeficiency virus serologic findings were positive. The chest roentgenogram showed a left lung abscess (Fig 1).

Salmonella enteritidis (group D) was isolated from the blood, sputum, and stool. The patient had a complete resolution of the lung abscess after three weeks of intravenous ceftriaxone and chloramphenicol and was discharged on a regimen of zidovudine and trimethoprim-sulfamethoxazole prophylaxis. He was readmitted in April 1990 with fever, but the chest roentgenogram was normal and the microbiologic cultures were normal. He has been followed up for five months with no recurrence.

Salmonella lung abscess has not, to our knowledge, been previously reported in AIDS. The excellent clinical response and absence of early relapse in our patient support the low pathogenicity of Salmonella in the respiratory tract, although the effect of trimethoprim-sulfamethoxazole prophylaxis cannot be excluded.

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REFERENCES


Lung Needle Aspiration for Diagnosis of Pneumonia

To the Editor:

I read with great interest in the October 1990 issue of Chest the excellent paper by Dr Torres and colleagues on the subject of percutaneous lung needle aspiration (PLNA) in patients with pneumonia. However, the authors' interpretation of our published data on this subject was not entirely correct. In that article, we reported a study on the diagnostic adequacy of tracheobronchial secretions for establishing the cause of nosocomial pneumonias in critically ill patients. In order to do this, we purposely studied only patients in whom a "gold standard" culture had firmly established the cause of the pulmonary infection. Thus, by definition, our study included only patients who had a positive PLNA result, since those with a negative result were automatically excluded from the final analysis. Obviously, under these circumstances, our report that 11 of 11 PLNAs were positive should not be construed to mean that the sensitivity of the procedure was 100 percent.

Torres and colleagues found a diagnostic sensitivity of 37.5 percent for PLNA in their patients. Reported sensitivities for PLNA in the context of pulmonary infections have varied widely, ranging from less than 40 percent to over 75 to 90 percent. Such variability in diagnostic yield is most likely due to such factors as differences in